CABINET FOR HEALTH AND FAMILY SERVICES

Office of Health Policy

(Amendment)

900 KAR 6:055. Certificate of need forms.

RELATES TO: KRS 216B.015

STATUTORY AUTHORITY: KRS 216B.040(2)(a)1

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.040(2)(a)1 requires the Cabinet for Health and Family Services to administer Kentucky's Certificate of Need Program and to promulgate administrative regulations as necessary for the program. This administrative regulation establishes the forms necessary for the orderly administration of the Certificate of Need Program.

Section 1. Definitions. (1) "Administrative escalation" means an approval from the cabinet to increase the capital expenditure authorized for a [~~on a previously issued~~] certificate of need project.

(2) "Cabinet" is defined by KRS 216B.015(6).

Section 2. Forms. (1) [~~OHP - Form 1, Letter of Intent, shall be filed by an applicant for a certificate of need pursuant to the requirements established in 900 KAR 6:065.~~

~~(2)~~] OHP - Form 2A, Certificate of Need Application, shall be filed by an applicant for a certificate of need unless the application is for ground ambulance services, change of location, replacement, cost escalation, or acquisition.

(2)[~~(3)~~] OHP - Form 2B, Certificate of Need Application For Ground Ambulance

Service, shall be filed by an applicant for a certificate of need for a ground ambulance service.

(3)[~~(4)~~]OHP - Form 2C, Certificate of Need Application For Change of Location, Replacement, Cost Escalation, or Acquisition, shall be filed by an applicant for a certificate of need for change of location, replacement, cost escalation, or acquisition.

(4)[~~(5)~~] OHP - Form 3, Notice of Appearance, shall be filed by a person who wishes to appear at a hearing.

(5)[~~(6)~~]OHP - Form 4, Witness List, shall be filed by a person who elects to call a witness at a hearing.

(6)[~~(7)~~] OHP - Form 5, Exhibit List, shall be filed by a person who elects to introduce evidence at a hearing.

(7)[~~(8)~~]OHP - Form 6, Cost Escalation Form, shall be filed by a facility that elects to request an administrative escalation.

(8)[~~(9)~~]OHP - Form 7, Request for Advisory Opinion, shall be filed by anyone electing to request an advisory opinion.

(9)[~~(10)~~] OHP - Form 8, Certificate of Need Six Month Progress Report, shall be filed by a holder of a certificate of need whose project is not fully implemented.

(10)[~~(11)~~]OHP - Form 9, Notice of Intent to Acquire a Health Facility or Health Service, shall be submitted by a person proposing to acquire an existing licensed health facility or service.

(11)[~~(12)~~]OHP - Form 10A, Notice of Addition or Establishment of a Health Service or Equipment, shall be filed by any health facility that adds equipment or makes an addition to a health service for which there are review criteria in the State Health Plan but for

which a certificate of need is not required.

(12)[~~(13)~~]OHP - Form 10B, Notice of Termination or Reduction of a Health Service or Reduction of Bed Capacity, shall be filed by a health facility that reduces or terminates a health service or reduces bed capacity.

(13)[~~(14)~~] OHP - Form 11, Application for Certificate of Compliance for a Continuing Care Retirement Community (CCRC), shall be filed by a facility to obtain a certificate of compliance as a continuing care retirement community.

Section 3. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) [~~"OHP - Form 1, Letter of Intent", 05/2009;~~

~~(b)~~] "OHP - Form 2A, Certificate of Need Application", 07/2015;

(b)[(c)] "OHP - Form 2B, Certificate of Need Application For Ground Ambulance Service", 05/2009;

(c)[(d)] "OHP - Form 2C, Certificate of Need Application For Change of Location, Replacement, Cost Escalation, or Acquisition ", 05/2009;

(d)[(e)] "OHP - Form 3, Notice of Appearance", 10/2015;

(e)[(f)] "OHP - Form 4, Witness List", 10/2015;

(f)[(g)] "OHP - Form 5, Exhibit List", 10/2015;

(g)[(h)]"OHP - Form 6, Cost Escalation Form", 12/2016[~~05/2009~~];

(h)[(i)]"OHP - Form 7, Request for Advisory Opinion", 05/2009;

(i)[(j)]"OHP - Form 8, Certificate of Need Six Month Progress Report", 07/2015;

(j)[(k)] "OHP - Form 9, Notice of Intent to Acquire a Health Facility or Health Service", 07/2015;

(k)[~~(j)~~] "OHP - Form 10A, Notice of Addition or Establishment of a Health Service or Equipment", 05/2009;

(l)[~~(m)~~] "OHP - Form 10B, Notice of Termination or Reduction of a Health Service or Reduction of Bed Capacity", 07/2015; and

(m)[~~(n)~~] "OHP - Form 11, Application for Certificate of Compliance for a Continuing Care Retirement Community (CCRC)", 05/2009.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Cabinet for Health and Family Services, Office of Health Policy, 275 East Main Street 4WE, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

900 KAR 6:055

REVIEWED:

Paul A. Coomes, Ph.D.
Executive Director
Office of Health Policy

11/1/16
Date

APPROVED:

Vickie Yates Brown Glisson
Secretary
Cabinet for Health and Family Services

12/7/16
Date

900 KAR 6:055

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held on January 23, 2017 at 9:00 a.m. in Suite B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by January 13, 2017, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation through January 31, 2017. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Administrative Specialist, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, phone 502-564-7905, fax: 502-564-7573, email tricia.orme@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Regulation: 900 KAR 6:055
Contact Persons: Diona Mullins, Office of Health Policy, phone (502)564-9592, email Diona.mullins@ky.gov; Tricia Orme, Office of Legal Services, phone (502) 564-7905, email Tricia.orme@ky.gov.

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation incorporates by reference certificate of need forms necessary for the orderly administration of the certificate of need program.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with the content of the authorizing statute KRS 216B.040(2)(a)1. "OHP-Form 1, Letter of Intent" is deleted to conform with a proposed change to 902 KAR 6:065, which eliminates the requirement for a letter of intent for formal review applications. "OHP-Form 6, Cost Escalation Form" is revised to simplify the required information to request a cost escalation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation incorporates by reference certificate of need forms.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation incorporates by reference certificate of need forms.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: "OHP-Form 1, Letter of Intent" is deleted to conform with a proposed change to 902 KAR 6:065, which eliminates the requirement for a letter of intent for formal review applications. "OHP-Form 6, Cost Escalation Form" is revised to simplify the required information to request a cost escalation.

(b) The necessity of the amendment to this administrative regulation: "OHP-Form 1, Letter of Intent" is deleted to conform with a proposed change to 902 KAR 6:065, which eliminates the requirement for a letter of intent for formal review applications. "OHP-Form 6, Cost Escalation Form" is revised to simplify the required information to request a cost escalation.

(c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation incorporates by reference certificate of need forms necessary for the orderly administration of the certificate of need program.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation incorporates by reference certificate of need forms necessary for the orderly administration of the certificate of need program.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Annually approximately 150 certificate of need applications are submitted.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: CON holders requesting an administrative cost escalation will be required to complete the revised "OHP-Form 6, Cost Escalation Form".

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There will be no additional cost to CON applicants to comply with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): "OHP-Form 1, Letter of Intent" will no longer be required and "OHP-Form 6, Cost Escalation Form" has been simplified.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: No cost

(b) On a continuing basis: No cost

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: No funding is necessary since there is no cost to implementing this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees and does not directly increase any fees.

(9) TIERING: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation: 900 KAR 6:055
Contact Persons: Diona Mullins, Office of Health Policy, phone (502) 564-9592, email Diona.mullins@ky.gov; Tricia Orme, Office of Legal Services, phone (502) 564-7905, email tricia.orme@ky.gov.

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Health care facilities owned by the state, county or city are required to complete certificate of need forms as appropriate.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. The authorizing statute is KRS 216B.040(2)(a)1.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate additional revenue for state or local government during the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate additional revenue for state or local government during subsequent years.

(c) How much will it cost to administer this program for the first year? No additional costs are necessary to administer this program during the first year

(d) How much will it cost to administer this program for subsequent years? No additional costs are necessary to administer this program for subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Office of Health Policy

900 KAR 6:055. Certificate of need forms.
Summary of Material Incorporated by Reference

"OHP-Form 6, Cost Escalation Form", revised December 2016, is being incorporated by reference. OHP-Form 6 shall be filed by a facility requesting a cost escalation. "OHP-Form 6, Cost Escalation Form" includes revisions to the following:

a. Page 1, #4 was revised to delete underlining of the word "Issued" and to delete the phrase "(see CON)".

b. Pages 1-2, #6 was revised to request total capital expenditure required for the project, capital expenditure authorized by the certificate of need or previously approved cost escalation, and the total cost escalation. Request for cost breakdowns for predevelopment, physical plant, other, and equipment costs were deleted.

c. Page 3, #9 was revised to clarify the question regarding obligation of an expenditure in excess of the amount authorized for a certificate of need project.

This form contains two (2) pages.

The total number of pages incorporated by reference in this administrative regulation is two (2) pages.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED

COST ESCALATION FORM

1. APPLICANT: _____

2. FACILITY/SERVICE NAME (if different): _____

3. CERTIFICATE OF NEED NUMBER: _____

4. DATE CERTIFICATE OF NEED ISSUED: _____

5. SCOPE OF PROJECT AS STATED ON CERTIFICATE OF NEED: _____

_____

_____

6. Please complete the following:

A. Total capital expenditure required for the project	$ _____
B. Capital expenditure authorized by certificate of need or previously approved cost escalation	$ _____
C. Total cost escalation (A – B)	$ _____

7. Please delineate the factors which have caused the cost escalation.

8. Has the scope of the project changed since the original approval in terms of proposed beds or services, square footage for construction projects, or other factors?
YES____ NO_____
If yes, please describe the change and explain why the change is necessary.

9. Has the CON holder obligated a capital expenditure in excess of the amount authorized by an existing certificate of need or a previously approved administrative escalation? KRS 216B.015(35) states: "'To obligate' means to enter any enforceable contract for the construction, acquisition, lease, or financing of a capital asset. A contract shall be considered enforceable when all contingencies and conditions in the contract have been met."

NO ____ YES _____ If yes, please indicate the amount of the obligation and date and type of obligation incurred.

10. I hereby declare to the best of my knowledge that the information provided on this form is true and accurate.

_____
(SIGNATURE OF APPLICANT) (DATE)

_____
(NAME – PRINT)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP CODE)

_____
(TELEPHONE NUMBER – INCLUDING AREA CODE)

_____
(EMAIL ADDRESS)

COMPLETE AND RETURN TO:

OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED
275 EAST MAIN STREET 4WE
FRANKFORT, KY 40621

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED

COST ESCALATION FORM

1. APPLICANT: _____

2. FACILITY/SERVICE NAME (if different): _____

3. CERTIFICATE OF NEED NUMBER: _____

4. DATE CERTIFICATE OF NEED ISSUED: [ISSUED (see CON)] _____

5. SCOPE OF PROJECT AS STATED ON CERTIFICATE OF NEED: _____

_____

_____

6. Please complete the following:

A. Total capital expenditure required for the project $ _____

B. Capital expenditure authorized by certificate of need or previously approved cost escalation $ _____

C. Total cost escalation (A – B) $ _____

[capital cost breakdown showing the capital expenditure authorized originally, the current capital expenditure required, and the amount of the escalation. Please be sure to complete each item in the cost breakdown as well as the total cost.

A. Predevelopment Costs

	A Origin	B Final	C(B&A) Escalation
(1) Preliminary and programming costs	$	$	$
(2) Site acquisition	$	$	$
(3) Architectural/engineering costs	$	$	$

B. Physical Plant Costs:

	A Origin	B Final	C(B&A) Escalation

(1) Construction and/or renovation cost (including fixed equipment)	$_____	$_____	$_____
(2) Building Acquisition (if applicable)	$_____	$_____	$_____
(3) Value of building or part of to be leased, donated, etc.	$_____	$_____	$_____
(4) Site improvement costs	$_____	$_____	$_____

C. Other

	A Origin	B Final	C(B&A) Escalation
(1) Financing costs (e.g., underwriter's discount fee's etc.)	$_____	$_____	$_____
(2) Interest during construction	$_____	$_____	$_____
(3) Contingency (e.g., change orders, etc.)	$_____	$_____	$_____
(4) Other (specify):_____	$_____	$_____	$_____

D. EQUIPMENT

	A Origin	B Final	C(B&A) Escalation
(1) Major medical movable equipment (value if leased, donated, etc.)	$_____	$_____	$_____
a. New	$_____	$_____	$_____
b. Replacement (5 years or older)	$_____	$_____	$_____
(2) Other equipment (value if leased, donated, etc.)	$_____	$_____	$_____
a. New	$_____	$_____	$_____
b. Replacement (5 years or older)	$_____	$_____	$_____
TOTAL	$_____	$_____	$_____]

7. Please delineate the factors which have caused the cost escalation.

8. Has the scope of the project changed since the original approval in terms of proposed beds or services, square footage for construction projects, or other factors?
YES____ NO_____
If yes, please describe the change and explain why the change is necessary.

9. Has the CON holder obligated a capital expenditure in excess of the amount authorized by an existing certificate of need or a previously approved administrative escalation? KRS 216B.015(35) states: "'To obligate' means to enter any enforceable contract for the construction, acquisition, lease, or financing of a capital asset. A contract shall be considered enforceable when all contingencies and conditions in the contract have been met."

NO ____ YES ____ If yes, please indicate the amount of the obligation and date and type of obligation incurred.

~~[Has the original "capital expenditure authorized" or any portion of the capital expenditure authorized been obligated as of this date through entering into enforceable contracts for the construction, acquisition, lease, or financing of capital assets or through internal commitments of funds by your governing body or the acceptance of donations of property? If obligations have been incurred, please indicate the amount of the obligation and the date and type of obligation incurred.~~
~~NO____ YES____ Please explain:~~

~~10. Please indicate the date and type of obligations expected to be incurred in the future for this project including obligation of the cost escalation.]~~

10. [~~11.~~] I hereby declare to the best of my knowledge that the information provided on this form is true and accurate.

_____
(AUTHORIZED SIGNATURE [~~OF APPLICANT~~]) (DATE)

_____
(NAME - PRINT)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP CODE)

_____
(TELEPHONE NUMBER – INCLUDING AREA CODE)

_____
(EMAIL ADDRESS)

COMPLETE AND RETURN TO:

OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED
275 EAST MAIN STREET 4WE
FRANKFORT, KY 40621

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED

LETTER OF INTENT

(Valid for a period of one year from date of filing)

1. NAME & ADDRESS OF FACILITY, PROGRAM OR SERVICE:

2. NAME & ADDRESS OF OWNER:
(Legally responsible person, corporation, or other entity who is or will be the license holder)

3. CONTACT PERSON:

Name:

Address:

City: State: Zip:

Telephone Number:

4. CITY & COUNTY OF PROPOSED SERVICE OR FACILITY:

City: County:

5. DESCRIPTION OF PROJECT: _____

_____

_____

6. DATE APPLICATION WILL BE FILED:

_____

7. FILED BY:

_____

(Authorized Signature) (Date)

_____

(Name - Print)

_____

(Title)

_____

(Address if different from question number 1 above)

COMPLETE AND RETURN TO:

OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED
275 EAST MAIN STREET 4WE
FRANKFORT, KY 40621]